Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BERNIE L MCCASKILL
8220 WALNUT HILL LN SUITE 310
DALLAS TX 75231

Respondent Name

HARTFORD INSURANCE COMPANY OF

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-13-1474-01

MFDR Date Received

February 12, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed please find DWC-60 listing the disputed charge for subject bill and date of service. Total disputed amount is $150.00

Also enclosed are copies of the medical bill as originally submitted and the explanation of benefits for that submission. Also attached is our request for reconsideration and explanation of benefits for that submission.

Request for reconsideration faxed to carrier on January 16, 2013, states carrier has paid maximum medical improvement only for an MMI/IR examination. No payment was made for the impairment rating given. Rule 134.204 (j) was attached with margin notes to indicate which parts of the rule applied to this examination."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No insurance carrier response received

Response Submitted by: n/a

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 03, 2012	CPT Code 99455-V3-WP	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 04, 2013

   - W1 – Workers Compensation State Fee Schedule Adjustment
   - QA – The amount adjusted is due to bundling or unbundling of services

   Explanation of benefits dated January 29, 2013

   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - QA – The amount adjusted is due to bundling or unbundling of services

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Requestor billed with CPT Code 99455-V3-WP in the amount of $325.00 with one unit billed.

   Review of the submitted the documentation supports that an examination for Maximum Medical Improvement (MMI) and Impairment Rating (IR) to one body area using the Diagnosis Related Estimates (DRE) method.

   Per Administrative Code §134.204 (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows, (3) The following applies for billing and reimbursement of an MMI evaluation, (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier, (i) Reimbursement shall be the applicable established patient office visit level associated with the examination, (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit, (4) The following applies for billing and reimbursement of an IR evaluation, (ii) The MAR for musculoskeletal body areas shall be as follows, (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.

   Therefore, CPT Code 99455-V3-WP is supported.

   The total reimbursement is $264.37.

2. The respondent issued payment in the amount of $114.37. Based upon the documentation submitted, additional reimbursement in the amount of $150.00 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		09/20/13
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.